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CHAPTER 2.0 PUBLIC POLICY AND NURSING HOME NURSE STAFFING¹

2.1 Introduction

In some very important respects, the nursing home market and characteristics of the nursing home population has changed considerably over the last several years. From 1987 to 1996 the number of nursing homes increased from 14,050 with a total of 1.48 million beds to 16,480 nursing homes and 1.76 million beds - about a 20% increase.² Currently, the total nursing home population in 1996 was approximately 1.56 million, a population with an increased level of functional disability. The percentage of residents needing help with three or more activities of daily living increased from 72% in 1987 to 83% in 1996. The nursing home market has remained largely proprietary with about 2/3 are for-profit nursing homes. Nearly 70% of these for-profit nursing homes are affiliated with a group or chain in contrast to less than 30% for nonprofit nursing homes. With the exception of State Certificate of Need policies that limit the nursing home bed supply in some States, most of these changes in the nursing home market and resident population appear to be outside the sphere of public policy decision making.

The proportion of nursing homes certified by both Medicare and Medicaid (dually certified) rose from 28% in 1987 to 73% in 1996. Meanwhile, the proportion certified by Medicaid-only fell from 50% in 1987 to only 17% in 1996. Although these proportions have changed, one important characteristic of the nursing home market has not changed: over 95% of all nursing homes are certified by Medicare, Medicaid, or dually certified. This near universality of certification has important public policy implications for nursing home staffing. Public policy impacts nurse staffing indirectly through payment

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² Rhoades J.A., Krauss NA. Nursing home trends, 1987 and 1996. Rockville (MD): Agency for Health Care Policy and Research; 1999. MEPS Chartbook No. 3. AHCPR Pub. No. 99-0032. The estimates presented here are from the 1996 Medical Expenditure Panel Survey (MEPS) Nursing Home Component (NHC) and the 1987 National Medical Expenditure Survey (NMES) Institutional Population Component (IPC). These estimates presented here are from a sample survey, nationally representative of nursing homes and their residents. Another national survey employing a somewhat different broader definition of a nursing home, the 1997 National Nursing Home Survey conducted by the National Center for Health Statistics, produces somewhat different estimates.

rates by Medicare and by individual State Medicaid nursing home payment systems usually administered by a rate-setting component of the State Medicaid bureau. In addition, public policy decision making impacts nurse staffing directly through quality regulations, including explicit nurse staffing standards administered by the State Health Departments and State survey agencies. These two spheres of public policy are discussed below.

2.2 Nursing Home Payment Rates and Nurse Staffing: Overview of Key Issues and Trends

The amount of money that nursing homes have to spend on staffing and other necessities is heavily dependent on public payment systems. In 1998, Medicaid paid for the care of 68% of residents, and Medicare paid for the care of 9% of residents. Twenty-three percent of nursing home residents paid privately (including about 2% who have long-term care insurance).³

These averages understate the importance of public payment systems in a majority of nursing homes because they mask the fact that in most States, most of the private paying patients, who typically pay higher rates than Medicaid and sometimes Medicare, tend to be concentrated in relatively few homes. Concomitantly, Medicaid patients tend to be disproportionately concentrated in nursing homes that are more heavily dependent on Medicaid payments. For example, in Ohio in 1994, nearly 10% of Medicaid patient-days were in facilities that were almost entirely reimbursed by Medicaid, that is, in these homes, 95% to 100% of all patient days were paid for by Medicaid.⁴

As seen in Table 2.1, growth in public spending on nursing homes declined from 1990 to 1998 and increased just 3.3% in 1998. This is the smallest increase since 1961 and is similar to the change that year in prices of items that nursing homes bought.⁵ Restrained growth of public spending reflects a confluence of factors including the reduced use of nursing homes and changes in public payment systems and rates. These factors are discussed in the sections below.

³ The American Health Care Association, *Facts and Trends: The Nursing Facility Data Book*, 1999.

⁴ B. Manard, *Long-Term Care Reimbursement and Financing: Analysis of Selected Issues*, prepared for the Ohio Department of Human Services, 1999.

⁵ In 1998, nursing home inflation as measured by the DRI market basket index was 3.2 percent. The index measures changes in the price of a set of goods and services that nursing homes purchase, including increases in the wages of nursing staff. The measure, which was redesigned in 1998 (it now includes a capital portion), incorporates a set of weights based on the relative proportions of various types of goods and services used in nursing homes, based on 1992 data. Previous versions of the index used weights derived from a 1977 study. The index would understate inflationary pressures on nursing homes if, for example, homes substantially increased the number of nursing staff, such that the weights derived from the 1992 study were no longer representative of the actual proportion of expenditures attributable to nursing staff.

Table 2.1 National Expenditures on Nursing Homes: 1990 through 1998					
Year	Total (\$billions)	Public Funds		Percent Change Over Previous Year	
1990	50.9	25.9
1991	57.2	30.6	18.1	11.8	19.0
1992	62.3	34.4	12.4	52.6	9.8
1993	66.4	37.9	10.2	34.5	7.3
1994	71.1	41.4	9.2	41.0	5.6
1995	75.5	44.4	7.2	25.5	3.8
1996	80.2	48.1	8.3	21.7	6.8
1997	84.7	51.3	6.7	14.3	5.3
1998	87.8	53.0	3.3	8.3	1.8
Source: HCFA, Office of the Actuary, National Health Statistics Group; January 10, 2000.					

2.3 Declining Nursing Home Demand and Occupancy Levels

Nursing homes are facing difficult marketplace issues that challenge their ability to provide sufficient staffing. The most widely discussed issue is the difficulty in attracting and retaining staff, given the increased competition for low-wage workers in a strong economy with low unemployment. Perhaps equally important is the changing demand for nursing home care.

As seen in Table 2.2, nursing home occupancy nationwide has declined substantially over the last decade. In 1998, just 81% of beds were occupied; median facility occupancy was 90%, down from 93% five years earlier.

Table 2.2 National Nursing Home Occupancy: One Day Census; Selected Years; 1973 through 1998			
Year	National Average (Total Residents/ Total Beds) %	Occupancy Rate of the Median and Mean Facility (50% of facilities have a lower occupancy rate than the median facility) %	
1973/74	91.4
1977	92.9
1985	91.8
1993	...	93	...
1994	...	93	...
1995	87.5	92	...
1996	..	91	...
1997	...	91	...
1998	81.0	90	84
Sources: Data on national averages (2nd column) except for 1998 are from the National Nursing Homes Survey for applicable years. All other data are from the OSCAR data file as reported in the American Health Care Association, <i>Facts and Trends: The Nursing Facility Data Book</i> , 1999. Other sources report slightly different numbers due to such things as different approaches to handling duplicates and computing annual totals. See Chapter 7.			

While occupancy levels are declining in most States, there is considerable variation across the country. For example:

- C New York has had a decade of high and virtually stable occupancy: occupancy was 98.7% in 1988⁶ and 96% in 1998.⁷
- C In Ohio, reflecting a common pattern among the States, nursing facility occupancy has declined about 1% per year since the early 1990s. In 1994, statewide occupancy for the year was 92 percent. By 1998, nursing home resident occupancy rates declined to eighty-eight percent.⁸

⁶ B. Manard, et. al, *Analysis of the New York State Capital Cost Reimbursement System for Residential Health Care Facilities*, prepared for the New York Department of Health, Office of Health Systems Management, 1990.

⁷ The American Health Care Association, *Facts and Trends: The Nursing Facility Data Book*, 1999, p. 35.

⁸ Personal communication with Stephen Plock, Ohio Department of Human Services, Division of Rate Setting.

- C In Texas, nursing home resident occupancy has consistently been among the lowest in the nation. Occupancy was approximately 80% in 1994 and dropped to approximately 71% in 1998.⁹
- C The decline in nursing facility occupancy rates reflects lower demand for nursing home care, particularly for longer stays. It is generally thought that this reduced demand reflects the increasing availability of assisted living and home care, although improved health and wealth among the elderly may also be factors reducing nursing home use as residential care facilities.
- In some States (Texas is a good example), there has been relatively little change in the number of beds, despite reduced demand. In other States, a combination of market factors and explicit State policy has led to reductions in the bed supply. Minnesota, for example, had 2,064 fewer beds in 1997, compared to 1987. Even with this reduction, statewide occupancy in Minnesota still declined slightly over the same period.¹⁰

Reduced demand for nursing home care affects the financial health of the industry in multiple ways. First, nursing homes' ability to serve larger proportions of higher paying private patients is optimized under conditions of high demand and constrained supply. In general, private demand is virtually always filled, though research shows that private pay residents are in fact price sensitive, limiting homes ability to raise private pay prices. As general demand declines, even when new bed development is constrained (i.e., occupancy declines), nursing homes become more dependent on public payment systems.

Second, declining demand impedes efforts to build facilities, which further impedes nursing homes' ability to compete with newer, attractive assisted living facilities for private pay residents. New construction is restricted in most States either by moratoria on certification and/or by Certificate of Need rules that tie bed supply to various indicators of demand and need. Additionally, it is more difficult to attract private capital where use rates are declining. Turmoil in the publicly traded nursing home markets since the implementation of the new Medicare Perspective Payment System (PPS) for skilled nursing facilities (SNFs) has made raising private capital on Wall Street particularly difficult. However, long-term trends, such as declining demand and uncertainty regarding public rates, erode the ability of even well established, community-based nursing homes to raise money for renovations or new buildings.

Third, declining occupancies rates in nursing homes increase per diem expenditures as fixed costs of care are spread across fewer residents. A nursing home's ability to recoup these increased per diem

⁹ Personal communication with Steve Lorenzen, Director of the Rate Analysis Department, Texas Department of Human Services.

¹⁰ Minnesota Department of Human Services, *Study of Nursing Facility Conversion: Recommendations for Capacity Reduction*, 1998.

costs from Medicaid and Medicare is substantially constrained. As discussed below, nearly all Medicaid payment systems have design features that limit or prohibit receiving per diem rate increases to cover the cost of declining occupancy. Medicare rates are virtually insensitive to changes in individual facilities' costs, other than those recognized by changes in case-mix or allowed national inflation adjustments.

2.4 Medicaid Rates

2.4.1 Key Factors in the Link Between Rates and Staffing

The degree to which Medicaid rates restrict (or enhance) nursing homes' ability *and* incentive to spend adequate sums of money for sufficient staff is a function of two key aspects of each State's rate-setting system: the level of payments and the level of detailed design features that define how closely rates are linked to actual costs.

Obviously, if a State sets Medicaid nursing home rates at \$25 per day where the average cost of providing adequate care was \$100 per day, nursing homes would not be able to care for Medicaid patients appropriately. However, it does not necessarily follow that if the State raised Medicaid rates to \$100 per day, all nursing homes could and would spend the money to improve staffing ratios and/or wages. In some States, there is virtually no link between what an individual facility spends and the rate it receives. Thus, higher rates might be taken in as profit or spent on capital improvements rather than on staffing. In most States, however, there is some relationship between the amount of money a facility spends and the rate it receives. In those States, there are stronger incentives for nursing homes to actually spend reimbursement money from Medicaid (or Medicare), rather than to hold expenditures down and increase profits, but there are numerous details of States' rate-setting systems that determine the precise incentives.

2.4.2 Variation Among States in Approaches to Medicaid Nursing Home Rate Setting

In every State, there is a wide range among nursing homes in total expenditures per patient day. For example, in Ohio in 1998, the least costly home spent just \$58.82 per patient day, while the most expensive spent \$641.78 per patient day; the average was \$121.25.¹¹ In Ohio, as elsewhere, the

¹¹ Personal communication with Stephen Plonck, Ohio Department of Human Services, Division of Rate Setting. Researchers have found that about 75% of the variation among nursing home costs in Ohio and other places are accounted for by a relatively small set of measurable factors: case-mix (the care needs of patients), facility occupancy, facility ownership (not-for-profit and government-owned homes spend more than for profit homes), facility type (nursing homes that are part of a hospital report higher costs than freestanding homes, even after taking other factors such as case mix into account), facility location (e.g., urban homes are more expensive than others, reflecting differential wages among other things), and facility

Medicaid rate setting system sets limits on the amount of nursing home costs that are reimbursed.

The strongest incentives for restraining the growing costs are found in payment systems that pay a price for care, regardless of individual facility expenditures. Such systems are called “flat rate” or “pricing systems.” The new Medicare SNF payment system is an example. Flat rate systems encourage facilities to reduce expenditures because they can profit from the difference between the payment rate and expenditures, but reductions in expenditures can reflect either improved efficiency or reduced quality (e.g., spending less on food and nursing care that patients actually need). Flat rate systems also raise issues regarding accountability, since homes that receive an increase are not required to spend it.

To achieve a balance between both cost containment and quality objectives, nearly all States use prospective payment systems and base payments in part on individual facility expenditures but use various limits to restrain cost.¹² Many States during the late 1980s and throughout the 1990s implemented rate-setting systems that placed stronger cost-containment incentives (e.g., paid flat rates) on the portion of rates less directly related to resident care (e.g., administration) and weaker cost-containment incentives (e.g., by limiting profit) on the portion of rates most directly related to care (e.g., nursing). In general, this continues to be a popular method. For example, each one of the four States (South Dakota, Maine, Mississippi, and Kansas) that implemented its first Medicaid case-mix system as part of the National Case-Mix and Quality Demonstration employed such “modified” cost-related case-mix strategies. In these and other States (e.g., Ohio, Nebraska, Pennsylvania), the RUGs case-mix measurement system as well as individual facility costs are used to determine key aspects of the relative discrepancy among rates for different types of patients.¹³

size (small homes and large homes tend to have higher costs per day than those in the mid range, all else being equal). States differ in the degree to which these factors are taken into account by Medicaid nursing home rates.

¹² Virtually all States use prospective systems to establish basic rates. That is, States prospectively establish rates for a coming year (e.g., 2001); homes that subsequently spend more than the rate paid are not reimbursed for the excess; homes that spend less than the rate paid are not required to repay the State. Prospective rates are designed to constrain costs and reduce the appeals and administrative burden associated with “settling up” retrospectively adjusted rates.

¹³ Approximately 60% of States now use some type of case-mix approach to setting Medicaid nursing home rates. In contrast to the way Medicare uses RUGs, to understand how case-mix measures are typically used by States it is helpful to first understand a simplified Medicaid rate-setting approach that does not take case-mix into account. The simplest model is a non-component-based, facility-specific, “cost-to-a-limit” model. To set rates under such a system for a rate year beginning January 1, 2001, and ending December 31, 2001, the steps would be as follows: (1) Calculate allowable per diem costs for each facility for a base year (e.g., January 1, 1999, through December 31, 1999). (2) Trend those costs forward using an inflation factor to the midpoint of the prospective rate year. (3) Array the per diem costs from high to low. (4) Identify the point on the array specified in law or regulation as the “limit” (i.e., the highest reimbursable cost). For example, the limit might be set at the 60th percentile or the median plus eight percent. (5) Pay each facility the lower of its allowable (trended) per diem costs or the limit.

One objection to finely tuned, component-based, modified cost-related systems is that they limit a provider's discretion with regard to how to spend rate money. However, this approach to targeting spending on nursing is less directive, and arguably less administratively complex than tying rate increases specifically to a particular aspect of spending, such as requiring providers to demonstrate that they increased nurse aide wages.

Only six States rely heavily on a nearly pure flat rate (pricing) system. Texas (until the coming changes discussed below) and California have the purest and longest standing examples. Oklahoma, Louisiana, Oregon, and Nevada also have systems that are typically classified as flat rates. In each of these six, however, there are special features that make the State system more cost-related than the Medicare system. In some, certain portions of the rates (e.g., capital and/or ancillaries) are paid on a facility or

In this non-case-mix rate setting example, per diem costs at each facility are calculated simply by dividing total allowable costs by total Medicaid days. This approach does not explicitly take into account the fact that some patients are more costly to care for than others, and thus, it penalizes facilities above the limits whose higher per diem costs are due to heavier care patients. To take case-mix into account, many States use both facility costs and RUGs to set rates. Each of the RUGs classes has an associated "relative resource use" weight. Heavier care patients have higher weights, reflecting the greater amount of nursing staff time required for these patients compared to an average patient.

To simplify a rate-setting example, assume a case-mix measurement system with just two classes of patients: "Heavy Care" (with a weight of 2.0) and "Light Care" (with a weight of 1.0). In this example, Heavy Care patients are considered twice as costly to care for as Light Care patients. Consider two facilities. Facility X had total nursing expenditures of \$3,650,000 and 36,500 patient days; its nursing costs per patient day were thus \$100 per day. Facility Y had total nursing expenditures of \$5,475,000 and 36,000 patients days; thus, its per diem nursing costs (\$150) were 1.5 times higher than that of Facility X. If the higher costs at Facility Y were due to inefficiency, a State would not want to pay those costs, but if the higher costs were due to heavier care patients, the State likely would not want to penalize Facility Y. To take case-mix into account, States typically *weigh* patient days before computing per diem costs and limits.

Assume that Facility Y has *only* Heavy Care patients and Facility X has *only* Light Care patients. Facility Y would have 72,000 weighted patient days ($2.0 \times 36,000$) and Facility X would have 36,500 ($1.0 \times 36,500$) weighted patient days. Dividing each facility's nursing costs by weighted patient days removes differences in case mix between the facilities. Thus, Facility X has case-mix adjusted per diem nursing costs of \$100 per weighted day; Facility Y has case-mix adjusted per diem nursing costs of \$75/weighted day ($\$5,475,000 / [2.0 \times 36,000]$). States use these facility-specific, case-mix adjusted costs to create an array of costs to which limits are applied. In the example, if the State paid patient-specific rates and both Facility X and Facility Y were below the State's limits, then, without adjustments for inflation, Facility X would get a rate of \$100 per day for every Light Care patient it took and twice that (\$200 per day) for every Heavy care patient it took. Facility Y would get \$75 per day for every Light Care patient and \$150 per day for every Heavy Care patient.

In contrast, if the State set case-mix rates using a pricing system (i.e., it ignored differences among facilities in actual spending), the rates may be set at somewhat like an average. For example, Facility X and Facility Y may each receive \$87.50 per day for a Light Care patient and \$175 per day for a Heavy Care patient. The arguments against using a case-mix measurement system to set prices, ignoring differences in spending among facilities, include (1) concerns about creating incentives for underspending and (2) concerns that even the best case-mix measurement system is insufficiently precise to capture variations among patients and facilities regarding the cost of caring for different types of patients.

patient-specific, cost-related basis. All provide for special exceptions and payments more reflective of costs for a limited number of patients with atypical needs. For example, although Texas has 11 different rates, one for each of its 11 different case-mix classes, it also has a small program for ventilator-dependent patients and a provision for paying for high-cost, out-of-state specialty care in exceptional cases.

2.4.3 The Effect of the Repeal of the Boren Amendment on Medicaid Rates

Medicaid is a joint Federal-State program. For most of the program's history, State payments for nursing homes have been subject to Federal requirements that reflect efforts to balance State flexibility and Federal oversight. In 1997, Congress determined that States needed greater flexibility and repealed the so-called "Boren Amendment," a section of the Social Security Act governing Medicaid rates for nursing homes and hospitals.

2.4.3.1 Background and Issues

In the early years of Medicaid, States nearly had a free hand regarding nursing home rate setting, limited primarily by the Federal requirement that the rates paid could not *exceed* those that would be paid using Medicare's "reasonable cost" principles.¹⁴ Many States developed rates purely as a budgetary exercise. To calculate the rate that was paid, the State divided the amount of money they had to spend by the estimated number of days of care that would be required. There was little information about how much nursing home care cost and how much homes were actually spending, regardless of the rate levels. Medicare, but not Medicaid, required uniform cost reports.¹⁵ Concerns arose regarding the appropriateness of States' Medicaid rates. The U.S. Senate held widely publicized hearings focusing on low rates, poor quality, and profiteering.

In response to concerns that States were underpaying for care in some cases and overpaying in others, the Social Security Amendments of 1972 required that Medicaid base nursing home reimbursement on "a reasonable cost-related basis." The regulations defined reasonable cost as "the level which the State reasonably expects would be adequate to reimburse in full any such allowable costs of a facility that is efficiently and economically operated." In response, a number of States simply adopted Medicare principles in an effort to comply with the new rules.

The Medicaid statute was amended again in 1980 for nursing homes and a year later for hospital

¹⁴ Portions of this section draw from a detailed analysis of the Boren Amendment and its predecessors found in: B. Manard, *Repeal of the Boren Amendment: Background, Implications, and Next Steps*; Washington DC, Georgetown University Institute for Health Care Research and Policy, 1997.

¹⁵ The Boren Amendment required that States develop uniform cost reporting systems for nursing homes, but this requirement was eliminated when Boren was repealed.

payments. The goal was to afford States greater flexibility because it was believed that the Medicare principles of nursing home payment, which retrospectively reimbursed costs with little restraint, were inherently inflationary. The new law, commonly known as “The Boren Amendment” after Senator David Boren, was amended again in 1990 to include a section, shown in italics below, reflecting the passage of the Nursing Home Reform Act (OBRA ’87). The Law required the following:

“[A State plan for medical assistance must] provide for payment of nursing facility services...through the use of rates which take into account the costs (*including the costs of services required to attain or maintain the highest practical physical, mental and psychosocial well-being of each [Medicaid resident]*)...which the State finds and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal quality and safety standards....” (Section 1902(a)(13)(A)).

Significantly, the Boren Amendment set forth both substantive and procedural standards for State rate-setters. Substantively, States were required to set rates sufficiently high to pay “efficiently and economically operated” facilities for providing appropriate care. In terms of procedure, States were required to “find” that rates were adequate.

Although there had been litigation over the adequacy of Medicaid rates since the inception of the program, controversy and litigation skyrocketed in the early 1990s spurred by a combination of factors. First, serious recession led to painful belt-tightening in many States. Since Medicaid payments constituted the single largest item in many States’ budgets, these payments were subject to close scrutiny during difficult economic times. Second, double-digit inflation in the cost of nursing staff made providers particularly sensitive to rate constraints.¹⁶ Third, increasing acuity of nursing facility patients (resulting in part from shorter hospital stays) and implementation of new quality standards gave credence to providers’ assertions of increasing cost pressures. Additionally, a set of important court cases fired a litigation explosion, with a preponderance of early wins going to providers. This set the scene for the States’ ultimately successful efforts to have the Boren Amendment repealed.

In 1990, the Supreme Court settled in *Wilder v. the Virginia Hospital Association* a long-standing controversy by ruling that providers did have enforceable rights to sue States in Federal court over Medicaid rates.¹⁷ The Supreme Court also importantly held that providers had separately enforceable

¹⁶ Increasing nursing costs in the early 1990s appear to have been largely driven by two factors. First, there was a temporary increase in difficulty of finding nursing staff (this abated somewhat before the current shortage). Second, and perhaps related to the first, there was a proliferation of contract (“rent-a-nurse”) agencies whose charges to nursing homes are higher than the costs of on-staff nurses.

¹⁷ *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990).

substantive and procedural rights under the Boren Amendment.¹⁸ Where judges might be reluctant to second-guess a State regarding the adequacy of rates given the difficulty of making that determination, cases relying heavily on procedural issues were more easily won. Two years after the Wilder decision, at least 20 cases challenging State Medicaid rates for nursing homes were filed, with the majority that went to court ultimately decided in favor of the providers.

States were more likely to win cases where they could show that rates had been set using established, technical formulae related to detailed analysis of cost report information, that at least half of facilities had had Medicaid rates covering 100% of allowable per diem costs, and that rates had kept pace with established indicators of nursing home inflation.

“Budget-driven” rate reductions made State systems particularly vulnerable because providers could point to Congress’ intent when passing the Boren Amendment “that a State not develop rates under this section solely on the basis of budgetary appropriations.”¹⁹ Similarly, cases involving contested inflation factors were common. Providers noted that Congress had specified at Boren’s passage that “the flexibility given the States is not intended to encourage arbitrary reductions in payments that would adversely affect the quality of care”²⁰ and that rates must take into account “economic trends and conditions” during the period for which rates were set.”²¹

By Boren’s repeal in 1997, the tide turned as States increasingly, though not entirely, prevailed in court. States had learned to develop explicit “findings” to document the rationale for their systems and to avoid changes in the rate system that raised flags. For example, rather than implementing across the board cuts, which could appear to a legislature the fairest and/or most politically feasible way to deal with a budget shortfall, States, mindful of Boren, could reduce the limits or profit factor, arguing that neither affected care at “efficient and economical” facilities. Additionally, more courts had applied less

¹⁸ Just prior to the Supreme Court case, the 10th Circuit ruled against a State in an influential case—*AMISUB (PLS), Inc. v. Colorado Department of Health and Human Services*. The case involved a challenge to Colorado’s Medicaid reimbursement system for hospitals. Medicaid reimbursed hospitals at a DRG-adjusted rate set at 88% of the Medicare rate. This rate was further adjusted by what the State called a “budget adjustment factor” (BAF), which multiplied the DRG rate by 54% to arrive at the final Medicaid rate. The Court decided in favor of the plaintiffs’ argument that by using a budget-driven rate-adjustment factor, the State had failed to meet the procedural requirements of the Boren amendment to make ‘findings’ which identified and determined efficiently and economically operated facilities and their necessary costs of operation. The Court found that under the Colorado system “no Colorado hospital recovered] its actual costs” even though “some...[were] efficiently and economically operated.”

¹⁹ H. Conference Report No. 99-1479.

²⁰ Senate Report No. 96-471.

²¹ Senate Committee on Finance, 96th Congress, 2nd Session, *Spending Reductions: Recommendations of the Committee on Finance* at 44-45 Comm. Print, 1980.

stringent procedural and substantive standards as States refined their arguments.²²

Although States increasingly prevailed in Court, providers strongly believed that the Boren Amendment provided needed protection for reasonable rates. Further, they argued that it was inappropriate for Congress to retain Federal quality standards but not Federal support for adequate rates.

2.4.3.2 *Preliminary Findings Regarding the Effect of Boren's Repeal*

In 1997, as part of the Balanced Budget Act, Congress repealed the Boren Amendment, although efforts to eliminate completely providers' ability to sue States in Federal court over rates were rebuffed.²³ Despite providers' fears that this change might lead to wholesale cuts in nursing home rates, States did not respond in this way. Nevertheless, the majority of States and State provider associations across the country believe that Boren's repeal contributed to downward pressure on the growth of Medicaid rates.

When Congress repealed the Boren Amendment, it also mandated a study, due in 2001, of the effect of its action. One part of the ongoing study involves interviews with Medicaid officials and State affiliates of the American Health Care Association in all States.²⁴ Preliminary results to date indicate the

²² For example, in 1994, providers challenged New Jersey over a reimbursement system that resulted in less than 15% of facilities receiving Medicaid rates that covered allowable costs, but the State prevailed. This case, *New Jersey Health Care Association v. Gibbs*, is the only case that tested the OBRA quality standard added to the Boren Amendment in 1990. The law specified that rates must account for facilities' necessary costs "including costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." Providers argued that "highest practicable" meant more than minimum licensure and certification standards and cited a New Jersey Health Department document that recommended, but did not require, that State's Medicaid rates could pay for higher staffing levels. The Court disagreed, concluding that "...the 'highest practicable' language does not impose any obligations beyond compliance with the requirements of OBRA '87... when Congress included the 'highest practicable' language as part of a series of miscellaneous technical amendments..., Congress anticipated that the 1990 amendments relating to the Medicaid program would 'reduce Medicaid program outlays'.... [T]he Court interprets the 'highest practicable' language to be the equivalent of, or a restatement of, the level of care and services required by applicable State and Federal standards...."

²³ After Boren's repeal, the remaining Federal substantive standard that governed states' responsibilities for appropriate rates is found in the so-called "equal access provision" (Section 1902(a)(30)(A)). This provision specifies in part that payments be "consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available...at least to the extent that [they] are available to the general population in the geographic area."

²⁴ The congressionally mandated study, under the direction of Christine Bishop of Brandeis University, is funded in part by the Commonwealth Fund and involves multiples ways of examining Boren's repeal including national econometrics analyses and interviews. As of April 2000, one round of interviews with State officials and AHCA affiliates has been completed in all but two States. Those interviews and additional ones to follow-up on States where key legislation was pending are currently underway. The

following:

- C In approximately 25% to 30% of States, both State officials and provider representatives have reported that Boren's repeal has had no apparent effect on rates or the rate-setting process;
- C In approximately 10% to 15% of States, there is strong evidence that Boren's repeal has been a factor affecting Medicaid rate developments, as acknowledged by all parties. For example, in Oregon, the Governor has cited specifically Boren's repeal in support of a proposal to increase rates by 2%, rather than by the 8% increase that would have occurred if a planned rebasing (5% increase) and an established inflation factor (2% increase) were used to compute new rates. Similarly, Nevada deferred a previously planned rate increase from 1999 to 2000 and Boren's repeal was part of the discussion.
- C In the remaining States, roughly 60%, at least one of the parties has reported that Boren's repeal had reduced at a minimum providers' negotiating strength and could have been a factor in rates' inability to keep pace with cost increases. In slightly over half the States, both parties agreed that Boren's repeal was a factor, though not necessarily a definitive one.

Strong economies in nearly all States have reduced pressure to squeeze rates, but competing State priorities (e.g., education) and State fiscal policies restrain a nursing home's ability to obtain rate increases concomitant with growth in State revenues, according to many respondents in the State survey.

For example, in Washington, "Initiative 601" limits growth in State spending to the combined effect of changes in the Consumer Price Index and population growth. State Medicaid officials have reported that this Initiative is the key factor driving budget decisions, but Boren's repeal possibly has had a minor, subtle effect on rate developments. Provider representatives view the effect as more substantial, but they agree that the relationship between rate developments and Boren's repeal could be subject to dispute. Washington was in the process of designing a new case-mix payment system when Boren was repealed. According to some, the absence of Boren has resulted in a more parsimonious system. In addition, as a legislative decision, rate increases in Washington, which uses 1996 costs as a base, have averaged around two percent. According to provider representatives, this is less than actual cost increases.

2.4.4 Study States: Ohio and Texas

Recent developments in Ohio and Texas further illustrate the range of changes in Medicaid payments that have occurred since Boren's repeal in the States where there has been an arguable, but not

completed report of the interview study, led by Barbara Manard, is forthcoming in mid-2000.

definitive, effect.

2.4.4.1 Ohio

Ohio was one of the earliest States to adopt a case-mix system and one of the last to switch from retrospective to prospective rates. In 1993, implementing prospective rates and adopting a version of RUGs as its case-mix measurement system, Ohio changed both features of its rate setting system, which replaced an older approach to varying payments with patient acuity. Nursing homes are now paid facility-specific rates, annually rebased with quarterly adjustment for any change in case-mix. Lower spending homes can profit on the difference between costs and the limits on property and, to a limited extent, on indirect costs. Homes below the limit that spend less on case-mix adjusted nursing costs in one year have lower rates in the following year.

After the first six months of the new system, a detailed analysis found that case-mix acuity and nursing expenditures increased more than spending in other areas, as intended.²⁵ At that time, nearly 55% of facilities received Medicaid rates that covered 100% of per diem costs. This is referred to as “55% cost coverage.”

Five years later, however, the State found that per diem costs increased faster than the rates: cost coverage for 1996 slipped to 37%. Further analysis, however, revealed that the slippage was largely due to declining occupancy and that the greater a home’s reliance on Medicaid, the more likely Medicaid rates covered costs fully.²⁶ Stated differently, Medicaid rates generally covered reported costs substantially, except for homes with low occupancy or a substantial proportion of private paying clients.²⁷ Thus, the State arguably would have prevailed had the Boren Amendment been in place and providers had sued for higher rates. On the other hand, there are cases from the early 1990s where providers did prevail in contesting similar cost coverage slippage.

Ohio recently implemented an updated version of the RUGs system but otherwise has made no major changes to the system. Provider groups have focused efforts on trying to obtain relief in two areas: occupancy minimums and disallowances for costs related to the use of contract nursing staff. In Ohio, as in most States, the State does not use providers’ actual occupancy in computing per diem costs for

²⁵ B. Manard and K. Coleman, *An Analysis of the Ohio Department of Human Services’ Medicaid Reimbursement system for NFs and ICFs-MR*, prepared for The Ohio Department of Human Services, 1996.

²⁶ B. Manard, *Long-Term Care Reimbursement and Financing: Analysis of Selected Issues*, prepared for the Ohio department of Human Services, 1999.

²⁷ Homes with large proportions of private-paying clients spend more and charge private payers more to cover the higher costs; many homes subsidize Medicaid clients with higher rates for private payers. In two States (Minnesota and North Dakota), State laws prohibit charging private payers more than Medicaid rates.

all rate components. Rather, it typically applies an “imputed occupancy factor” to the calculation of per diem fixed costs (capital) and sometimes to variable costs such as staffing. In these cases, it uses the greater of a home’s actual patient days or the number of days equivalent to a specific level of occupancy (e.g., 90%) to compute per diem costs in rate-setting analyses. The rationale for these imputed occupancy factors is that homes with low occupancy are not economically efficient. In addition, a home with low occupancy could be a home with quality problems that potential customers are avoiding. Providers in Ohio and other States have contended that previously set occupancy factors are too low in light of changing market conditions. To date, Ohio has not changed the minimum imputed occupancy but is considering to relax disallowances for the costs of contracting nursing staff.

2.4.4.2 Texas

As noted above, Texas has long been one of the few States that paid “flat rates.” That is, rates are set based on analyses of all facilities’ costs, but every provider receives the same rate for each of 11 case-mix classes, regardless of what that facility spent. In 1990, contesting the level of flat rates (i.e., how much money each home received), providers prevailed in a Boren suit against the State.

Over the years, some in Texas have argued for abandoning the flat rate system to afford greater accountability for spending. Those who successfully opposed implementing a modified cost-related system argued that it would be inflationary and that higher spending facilities, disproportionate nursing homes with fewer Medicaid recipients and disproportionate not-for-profit homes, were less efficient and thus should not be rewarded with higher rates reflecting their higher costs. Although the State found that, in theory, it could implement a modified cost-related system on a budget neutral basis, doing so would mean reducing the profits of lower spending facilities to cover the costs of higher spending facilities.

Over the last few years, however, key members of the State Legislature have grown more interested in quality issues and in the relationship between rates and quality. This changed circumstance was an important factor in the recent passage of legislation that will tie a substantial portion of scheduled rate increases to staffing ratios.

Rules for the new system are still being refined.²⁸ As of April 2000, the key features of the new system would work as follows:²⁹

²⁸ A hearing on proposed rules was held in early March 2000.

²⁹ Personal communication with Steve Lorenzen, Director of the Rate Analysis Department, Texas Department of Human Services.

- C The State has a fixed budget earmarked for the nurse staffing enhancement program.³⁰ The budget is sufficient to pay for roughly 10-15 minutes per resident day of LPN time (or the equivalent cost of RNs or aides) for each nursing home, should all apply.³¹ The funds will be evenly allocated among those requesting participation up to the maximum in the budget. That is, funds will not be allocated based on detailed analysis of “need,” in part because the legislature has required exceptionally fast implementation of this potentially complex program.
- C Participation in the program is voluntary.
- C Providers that choose *not* to participate will receive just a 1.6% increase in rates at the start of the new rate year in September.
- C Any provider, regardless of current nurse staffing, may submit a request for funds for nurse staffing enhancements during the upcoming open-enrollment period.
- C Homes will not be asked initially to submit documentation regarding current staffing.
- C At the end of six months, participating homes will submit documentation regarding nurse staffing. At that time, the nursing homes’ staffing will be compared to a case-mix adjusted standard which the State has determined to be equivalent to the amount covered by the regular case-mix rate, discounted somewhat. The State has currently set that standard at a point approximately 6% below statewide average staffing, adjusted for case-mix.
- C Homes whose staffing at six months falls below the sum of the standard plus the additional staffing covered by the extra payment received will be required to return money to the State.
- C Homes whose staffing already substantially exceeds the State standard will be able to receive supplemental staffing funds and keep them, regardless of whether or not expenditures on staff are increased. In these cases, it is argued that the new system is more fairly recognizing the higher staffed nursing homes’ on-going efforts.
- C In addition, all homes, whether or not they participate in the new program, will be required to actually spend at least 85% of the direct care rate.

The new approach represents a substantial departure from Texas’ long-standing flat rate approach in

³⁰ Roughly \$50 million was carved essentially out of money that would have been spent on across-the-board, non-targeted rate increases, had the State simply applied its previous rate methodology.

³¹ In other words, the budget can provide sufficiently for approximately one RN or three aides at an average home, should all apply.

that a portion of the rates are tied to facility-specific spending on nursing. In effect, there is a new facility-specific, case-mix adjusted floor that could promote increased spending for nurse staffing among previously low-spending facilities.

Notably, the Texas approach is *explicitly* budget-driven. Although many factors have contributed to Texas' decision to change its system, adopting an explicitly budget-driven system would have risked litigation prior to Boren's repeal. Boren's repeal in Texas appears to have contributed to real changes the legislature might not have been willing to make (i.e., tying rates in part to facility spending) if it had not been able to explicitly tie most of the "inflation" adjustment to an explicit legislative program and budget.

2.5 Medicare Payments

On average, Medicare payment rates appear less important to nursing home finances than Medicaid because only about 9% of patients on any one day nationwide have care paid for by Medicare, compared to about 69% for whom Medicaid is the primary payer. However, Medicare payments are more important than it appears from these averages. First, in some cases where Medicaid rates were low, Medicare payments have covered some of the shortfall.³² Second, prior to the implementation of the new Medicare payment system in 1998, a substantial proportion of facilities and national chains had aggressively pursued Medicare patients. Thus, some "subacute care" facilities, specializing in shorter stay and Medicare patients, have been affected considerably more than others by changes in Medicare's payment policies for nursing homes. As with Medicaid, two key factors about Medicare payments are important to staffing issues: the *amount* of the payments and the *structure* of the payment system.

With regard to the amount of payments, provider associations, citing the fact that companies owning approximately 10% of the nation's nursing homes have filed for bankruptcy protection since the new system was implemented, have argued that Medicare's new case-mix payment system sets rates too low.³³ Others, including the General Accounting Office, have contended that Medicare's new payment system is just one reason for the bankruptcies and that management decisions, including debt-financed fast-growth strategies fueled by profit opportunities under the previous Medicare payment system, are also important factors. Regardless of its cause, the current turmoil in nursing home markets has raised concerns about the effect on quality and staffing. These issues are discussed in a subsequent chapter.

³² Although Medicare rates generally have been higher than Medicaid rates, it is difficult to determine whether Medicare has subsidized Medicaid or vice versa. This likely varies by facility and State. The difficulty arises because prior to 1998 Medicare rates were based on *average* costs; however, as shown by considerable research, Medicare patients are generally more costly to care for than others.

³³ See, for an example of provider concerns: Tracey Blankenheim, "Bankruptcies Make Future of Subacute Care Uncertain," *McKnight's Long-Term Care News*, March 27, 2000, p. 23.

In addition to issues regarding the level of Medicare payments, the structure of the payment system has implications for staffing. Medicare's new payment system is more like a pure "pricing" system than virtually any State Medicaid system or Medicare hospital payment system.³⁴ This structural feature raises three key issues with regard to rates and staffing. First, it is difficult to be assured that rates paid are actually appropriate for the care needs of patients (i.e., neither too low or too high) when much depends on the precise accuracy of the RUGs case-mix measurement system.³⁵ Second, the system has strong incentives for providers to reduce spending, including that on nursing staff. Third, some policy makers have expressed concerns regarding system accountability. For example, at a recent congressional hearing on nursing home staffing, Representative Pete Stark noted, "...while Medicare is now paying for adequate staffing on an acuity basis, there is no requirement for facilities to actually *provide* that level of staffing."³⁶ He further noted an intent to introduce legislation that would specifically tie Medicare payments to actual staffing, reflecting the same concerns that led the Texas legislature to change its Medicaid pricing system.³⁷

2.6 State Licensure Minimum Nurse Staffing Requirements

As discussed in Chapter 1, all nursing homes that are certified to receive payment under Medicare or Medicaid must meet minimum Federal nurse staffing requirements.³⁸ However, this Federal minimum does not preclude individual States from waiving the Federal standard or imposing more specific requirements under their licensing authority.³⁹ Thus, a number of States have outlined their own

³⁴ For example, the hospital payment system includes provision for outlier payments, while the SNF payment system does not.

³⁵ Questions have been raised about (1) the degree to which the basic RUGs system appropriately explains variations in resource use among the full range of patient types, given the relatively small samples of Medicare patients on which RUGs is based, and (2) the degree to which the *payment* system appropriately accounts for variations among patients in the specific costs of non-therapy ancillaries. Studies of these issues have been completed. As of April 2000, an updated SNF payment rule is pending.

³⁶ Committee on Aging, November 3, 1999; emphasis in the original.

³⁷ Specifically, Representative Stark said, "In the near future, I will introduce legislation to make Medicare-reimbursed skilled nursing facilities accountable for periodically reporting nursing staff data...in a similar manner as is done for cost reports. In cases where staffing levels are found to be out of step with the case-mix of the facility's residents, then Federal payments would be adjusted" (Committee on Aging, November 3, 1999).

³⁸ The current Federal nursing home nurse staffing requirements are detailed in Chapter 4.

³⁹ There is a perception by many that HCFA's current (non-ratio) minimum nurse staffing requirements are often waived. Although HCFA regulations still permit the 8 hr. RN and 24 hr. licensed coverage per day to be waived (see ref chap. 4), very few nursing homes, almost negligible, currently receive a waiver. As of March 11, 2000, the current surveys in OSCAR indicate that only 27 facilities throughout the United States

provisions for nurse staffing. In addition, some States have recently enacted or have pending legislative efforts directed towards staffing in nursing homes as well as home health care.

The purpose of this section is to describe: 1) variability of nursing home nurse staffing requirements under State licensure; 2) the specific State licensure requirements for the study States - Ohio, New York, Texas; and 3) current and/or pending State legislation in this area.

2.6.1 General Description of State Licensure Requirements

As described in Chapter 1, Federal regulations⁴⁰ assert that long-term care facilities under Medicaid/Medicare must have “sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.” Recent changes to the State Operations Manual⁴¹ (SOM) provide further guidance to surveyors for determining whether a facility meets Federal nurse staffing standards. Since Federal regulations and manual instructions neither specify nor operationalize what constitutes “sufficient nursing staff,” some surveyors state they have difficulty defending a staffing citation because of this lack of specificity. However, it appears that providers, payers, and surveyors have some latitude as to how this general requirement is applied.

In conjunction with the National Committee to Preserve Social Security and Medicare and with support from the Service Employees International Union (SEIU), the National Citizens Coalition for Nursing Home Reform (NCCNHR) has prepared an ongoing state-by-state compilation of the minimum staffing requirements as of October 1999 (See Appendix A1). The report found 14 States have not imposed any additional criterion to the Federal standard. For instance, Kentucky’s Division of Licensing and Regulation has stated that a minimum staff requirement would become the maximum, ratios could not be predicted because of the unpredictability of acuity levels, and ratios would hinder the survey process. Thirty-seven States have passed laws and regulations that impose more specific requirements to the Federal standard. These State requirements are extremely varied and are based upon one or more of the following: number of beds, number of hours per patient per day, care and service needs, and shifts. In Table 2.3, we provide a brief comparison of known State requirements, as stated in regulation or law. However, we did not take into account the actual interpretation and implementation of these standards. In this summary table, it should be noted that even for States that require only the Federal

have received a waiver of either the RN or LPN coverage requirements. Twenty-three of these 27 waivers come from just two states, Minnesota and Oklahoma. In addition, even for the very few nursing homes that receive a waiver, they do not have the entire coverage requirements waived. For example, for those that have received a RN waiver, the average number of hours waived is 21.5 hrs. per week.

⁴⁰ 42 CFR 483.30

⁴¹ State Operations Manual, Appendix P, pages 51-52, Task 5C

minimum, this does not preclude facilities from exceeding that minimum, sometimes going beyond the minimum. Hence, States that require only the Federal minimum may possibly have an actual average staffing ratio that exceeds that of other States that impose additional State minimum requirements⁴².

Table 2.3 Comparison of State Staffing Requirements (Stated in Regulation or Law) to Federal Standards. This table is derived from NCCNHR's compilation of State staffing standards (Appendix A1).		
No State Regulation/Law*	Less Demanding State Standards**	More Demanding State Standards ***
Alabama Arizona District of Columbia Kentucky Missouri Nebraska New Hampshire New Mexico New York North Dakota South Dakota Vermont Virginia Utah	Alaska Colorado Connecticut Delaware Hawaii Indiana Iowa Kansas Louisiana Maryland Minnesota Montana North Carolina Ohio Oklahoma Oregon Rhode Island Tennessee Texas Washington West Virginia Wyoming	Arkansas California Florida Georgia Idaho Illinois Maine Massachusetts Michigan Mississippi Nevada New Jersey Pennsylvania South Carolina Wisconsin
<p>* These States do not specify any additional nurse staffing requirements to the Federal standard.</p> <p>** These States have specified nurse staffing requirements through law and/or regulation, in addition to the Federal requirement. See the following note.</p> <p>*** States categorized in this column require more than 2.25 hour per resident day or more than one staff member to nine residents in the day shift, 13 residents in the evening shift, and 22 residents in the night shift.</p>		

Though the majority of States have established nurse staffing requirements, they vary considerably. Twenty-eight States have expressed their requirements as the hours of nursing care per patient per day, while 11 States have expressed their requirements as a ratio of staff members to residents. Besides

⁴² This is further discussed in Chapter 3.

having general staffing ratios or required nursing hours, States have established other policies related to staffing. For instance, in 7 States, a facility must have a RN present 24-hours per day, 7 days per week in 7 States. Twenty-one States allow waivers⁴³ of nursing requirements for Medicare and/or Medicaid facilities.

An examination of the Appendix A reveals the variability in State standards that further define Federal standards. For example, Hawaii's regulations (See Appendix A1, page 10) requires at least one RN, 24 hours per day, 7 days per week in a SNF. West Virginia's requirements (See Appendix A1, page 30-32), on the other hand, are much more complicated and detailed. Based upon the number of residents, West Virginia's ratios depend on the number of licensed/non-licensed personnel per resident.

2.6.2 Specific State Licensing Requirements for the Study States

The diversity in State regulations and statutes for nursing home nurse staffing is exemplified in the three States in our study. New York follows Federal regulations without any further State specifications. Texas, on the other hand, requires that at a minimum, each facility must maintain a ratio of one licensed nursing staff person for every 20 residents or a minimum of 0.4 licensed-care hours per resident day. Of the three study States, Ohio appears to hold the most detailed requirements. In Ohio, each nursing home must have:

- C at least one attendant on duty for every 15 residents at all times and one other person on duty at all times.
- C at least one person working 40 hours per week for every 4 residents.
- C with ten or fewer residents, one nurse on duty at least 8 hours per day between 6:00 AM and 5:00 PM and a nurse on call at all other times.
- C with 11 to 25 residents, one nurse on duty at least 16 hours per day between 6:00 AM and 12:00 AM and a nurse on call at all other times.
- C with 26 to 50 residents, one nurse on duty at all times.
- C with 51 to 75 residents, two nurses on duty at all times, provided that at least one nurse shall be an RN on duty not less than eight hours between 6:00 AM and 5:00 PM.
- C with 76 to 100 residents, at least two nurses. The RN shall be on duty not less than eight hours between 6:00 AM and 5:00 PM.

⁴³ Many perceive that HCFA's current (nonratio) minimum nurse staffing requirements are often waived. Although HCFA regulations still permit the 8-hour RN and 24-hour, licensed coverage per day to be waived (see chapter 4), very few nursing homes, almost negligible, currently receive a waiver. As of March 11, 2000, the current surveys in OSCAR indicate that only 27 facilities throughout the United States have received a waiver of either the RN or LPN coverage requirements. Twenty-three of these 27 waivers come from just two States, Minnesota and Oklahoma. In addition, even for the few nursing homes that receive a waiver, they do not have the entire coverage requirements waived. For example, for those that have received a RN waiver, the average number of hours waived is 21.5 hours per week.

- C with more than 100 residents, an RN on duty at all times and an additional nurse on duty at all times for every 50 residents.

Although both Ohio and Texas have additional minimum ratio requirements, the required ratios in Ohio depend upon resident-specific characteristics. Since the distribution of these other characteristics differs between the two States, it is difficult to determine if the net effect of Ohio's more complicated requirements results in a higher State average nurse staffing ratio.

2.6.3 State Legislation Activities in 1999 Related to Nurse Staffing

Nurse staffing in long-term care has caught the attention of lawmakers across the nation (See Appendix A2). Recently, Arkansas, California, South Carolina, and Wisconsin have adopted new laws to increase minimum requirements for nurse staffing. As of November 1999, legislative proposals in this area have been introduced or are being considered in 19 States. Of these 19, two proposals have passed through committee⁴⁴, two are pending⁴⁵, and one has passed the State legislature⁴⁶. Three States⁴⁷ have considered or are considering changing nurse staffing requirements through regulations. In addition, task forces have formed in some of the States, and they have taken a significant role in proposing legislation.

Other States are seeking methods to attract a larger labor pool by increasing wages. The North Carolina Division of Facility Services (NCDFS) reported in September 1999 that seven States had minimum wage rates that were above Federal standards⁴⁸ (Appendix A3). A recent trend has been the implementation of a "pass-through" wage increase where all or a portion of an increase in provider reimbursement is allocated exclusively for nurse staffing salaries and/or benefit. As explained by NCDFS, ten States⁴⁹ have implemented Medicaid wage pass-throughs based on a set dollar amount for workers per hour or patient day. The amounts of these pass-throughs range from \$0.50 per hour to \$2.14 per hour and \$4.93 per patient day. Six States⁵⁰ have established wage pass-throughs as a

⁴⁴ New Jersey and New York

⁴⁵ Maine and Michigan

⁴⁶ New Mexico

⁴⁷ District of Columbia, Mississippi, and Pennsylvania

⁴⁸ The current Federal minimum wage is \$5.15 per hour.

⁴⁹ Arkansas, Colorado, Massachusetts, Missouri, Oregon, Rhode Island, South Carolina, Texas, Virginia, and Washington

⁵⁰ California, Illinois, Maine, Michigan, Minnesota, and Montana

percentage of the increased reimbursement rate. Three States⁵¹ have implemented a wage pass-through for all of long-term care. Nine States⁵² have passed a wage pass-through specifically for home care workers and four States⁵³ for nursing home CNAs. Furthermore, other States are attracting nurse aides by other means that include offering financial incentives to enhance standards, raising State reimbursement rates for shift differentials, requiring transportation reimbursement, establishing nurse aide career ladders, and placing emphasis on training.

For Ohio, New York, and Texas, State legislatures have considered more stringent requirements, which are outlined in Appendix A4. In Texas, nurse aide ratios were proposed in House Bill 1225, which would have required nurse aide ratios of 1:8 (day), 1:10 (afternoon), and 1:14 (night). The Ohio bill calls for more specific and stringent ratios for nurses and nurse aides. Lastly, New York's bill, which has been introduced in both the State Assembly and Senate, pushes a number of provisions, including rigorous staffing standards for RNs, licensed personnel, and CNAs based upon shift. These proposed legislative changes were not passed and implemented for the study period discussed in several chapters of this Report. However, it is possible that the general concern with staffing that led to proposed legislative changes noted here and throughout the nation may have impacted staffing levels prior to any newly implemented policies.

2.7 Conclusions

The sections above demonstrate that there has been increased concern across the country regarding adequate staffing in nursing homes among both those responsible for licensure standards and rate-setters. At least 36 States and the District of Columbia have imposed new, more stringent staffing requirements under their State licensure authority and 19 States have introduced State legislation in this area. Further, at least 10 States now explicitly tie some portion of rates to staff levels or wages and there has been some discussion of adding some feature like that to Medicare payments.

Despite considerable variation among State Medicaid payment systems and between Medicare and Medicaid, all of the nation's public payments for nursing homes are fundamentally driven by historical spending patterns.⁵⁴ Thus, in general, if nursing homes have been historically understaffed, then some

⁵¹ Minnesota, Montana, and Virginia

⁵² Colorado, Illinois, Massachusetts, Missouri, Oregon, Rhode Island, South Carolina, Texas, and Washington

⁵³ Arkansas, California, Maine, and Michigan

⁵⁴ While independent of any one facility's spending on nursing home care, Medicare's case-mix rates are in substantial part a function of what nursing homes were spending in the 1995 base year trended forward by various inflation factors. Thus, even if the staff times embedded in the RUGs system represent optimal staffing levels, payment rates still could be too high or too low because rates were set using historical

public payments could require adjustments if policy makers choose to require substantially different staffing patterns. If adjustments to Medicare's payments were considered, policy makers would need to consider both the level of payments and the advantages and disadvantages of payments that are more closely tied to actual spending on staffing than the current system. These structural features of payment, as noted above, are important to both a system's incentives and its overall cost.

costs. For example, it has been argued that the cost reports used to set Medicare SNF rates were inadequately audited and hence, rates may be too high relative to actual allowable spending. In addition, one might ask whether facilities were optimally staffed in the base year.